State of California Department of Consumer Affairs

**Speech-Language Pathology and Audiology Board**
1422 HOWE AVENUE, SUITE 3, SACRAMENTO, CA 95825-3204
TELEPHONE: (916) 263-2666/ FAX: (916) 263-2668
www.slpab.ca.gov

# *CONSUMER COMPLAINT FORM*

***PLEASE PRINT OR TYPE***

| **PERSON REGISTERING COMPLAINT** | | |
|---|---|---|
| **NAME OF PATIENT** | | |
| **NAME OF PERSON LODGING COMPLAINT**<br><br>**RELATIONSHIP TO PATIENT:** | **HOME TELEPHONE ( )**<br><br>**WORK TELEPHONE ( )** | |
| **ADDRESS (NUMBER AND STREET)** | | |
| **CITY** | **STATE**<br>CA | **ZIP CODE** |

| **PERSON COMPLAINT REGISTERED AGAINST** | | |
|---|---|---|
| **NAME** | **BUSINESS TELEPHONE**<br>**( )** | |
| **ADDRESS** | **LICENSE NUMBER: (If known)** | |
| **CITY** | **STATE**<br>CA | **ZIP CODE** |

| **DETAILS OF COMPLAINT** | |
|---|---|
| **DATE OF VISIT**<br><br>_____/_____/_____<br>Month Day Year | **HOW LONG HAVE YOU BEEN A PATIENT?**<br><br>_____ **Yrs.** _____ **Mos.** |

Attach additional page(s) if more space is needed.

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I authorize the release of any information relating to my case from any speech-language pathologist, audiologist, or any health care practitioner who has provided treatment to me, including those persons listed above. I further agree that the Board and its representatives may release any and all of my records and treatment information to the Hearing Aid Dispensers Bureau and/or any other governmental agency which requests such information as part of an investigation into other possible violations of California laws and regulations

*The above information is a true and accurate statement regarding my complaint.*

Signature

Date